STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255179	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leakesville Rehabilitation and Nursing Center, Inc	1300 Melody Lane Leakesville, MS 39451

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interviews, record review, and facility policy review, the facility failed to ensure the call light system accommodated the needs of a resident with contracted hands for one (1) of four (4) survey days that affected Resident #5.Findings include:A review of the facility's policy, Call Lights: Accessibility and Timely Response, dated 10/21/24, revealed, .Policy Explanation and Compliance Guidelines.3. Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system.A record review of the admission Record revealed the facility admitted Resident #5 on 2/13/23 with current diagnoses including Hemiplegia and Hemiparesis and Contractures of Right and Left Arms and Legs.A record review of the Skilled Evaluation dated 8/29/25, revealed Resident #5 had Impairment on both sides regarding upper and lower extremity range of motion and indicated he had contractures.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/29/25 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 05, which indicated he had severe cognitive impairment. Section GG revealed impairment to his upper and lower extremities.On 9/22/25 at 12:35 PM, during an observation and interview, Resident #5 was yelling for help. Upon entering the room, the resident explained he needed a nurse. The resident's call light was observed to be a push-button type with the cord wrapped around the bed rail. Resident #5 explained he could not grasp the call light due to his contracted hands.On 9/22/25 at 12:45 PM, during an interview with Licensed Practical Nurse (LPN) #2, she confirmed that the push-button call light was not adequate for Resident #5 because he was unable to press the button.On 9/23/25 at 3:10 PM, during an interview with the Administrator, she explained she was unaware of who determined which residents should be provided with alternative call lights. She believed an assessment should have been completed upon admission by clinical nursing staff.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on staff interview, record review, and facility policy review, the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) assessment following the placement of a percutaneous endoscopic gastrostomy (PEG) tube for one (1) of 17 sampled residents. (Resident #1). Findings include:A review of facility's policy, MDS (Minimum Data Set) 3.0 Completion, dated 9/24/24, revealed, .Residents are assessed .in order to identify care needs.Policy Explanation and Compliance Guidelines.2d. Significant Change in Status Assessments (SCSA) - a comprehensive assessment completed within 14 days of the identification of a status change that meets the requirements.i. A significant change is a major decline or improvement in a resident's status that : (1) will not normally resolve itself without intervention by staff or by implementing standard disease-are of the resident's health status.requires interdisciplinary review and/or revision of the care plan.A record review of the admission Record revealed the facility admitted Resident #1 on 4/14/25 with current diagnoses including Encounter for Attention to Gastrostomy.A record review of the Encounter Procedures and Lab Test (Detail)report dated 6/13/25, revealed Resident #1 had a Successful 18-French gastrostomy tube placement.A record review of the MDS submissions data revealed there was no Significant Change in Status MDS completed for Resident #1 after the PEG tube placement on 6/13/25 On 09/25/2025 at 8:29 AM, during an interview with Registered Nurse (RN) #1, she confirmed that a Significant Change MDS was not submitted following Resident #1's PEG tube placement. RN #1 explained that Skilled MDS assessments were submitted on 6/22/2025, but a Significant Change assessment was not completed because she believed two areas of decline must be present for it to be required. RN #1 stated that staff anticipated a continued decline in the resident's health if the PEG tube had not been placed.On 09/25/2025 at 12:59 PM, during an interview with the Administrator, she stated her expectation was that staff follow the Resident Assessment Instrument (RAI) User's Manual guidance regarding the completion of Significant Change MDS assessments.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to complete a bedrail assessment and obtain resident consent to ensure safe and appropriate bedrail use for one (1) of three (3) sampled residents reviewed for accidents/bedrails. (Resident #34).Findings include:A review of the facility's policy, Proper Use of Bed Rails, dated 2/5/2025, revealed, .It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bedrails. ?Bed Rails' are adjustable metal or rigid plastic bars that attach to the bed. Examples of bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars. Resident Assessment 1. As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bed rails meets those needs: . k. Mobility (in and out of bed) . 4. The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself. Informed Consent 6. Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. Installation and Maintenance of Bed Rails 12. The facility will assure the correct installation of bed rails, prior to use. iii. Inspecting and regularly checking the mattress and bed rails for areas of possible entrapment . Ongoing Monitoring and Supervision 15. The facility will continue to provide necessary treatment and care to the resident who has bed rails in accordance with professional standards of practice and the resident's choices. c. Ongoing assessment to assure that the bed rail is used to meet the resident's needs d. Ongoing evaluation of risk . 16. Responsibilities of ongoing monitoring and supervision are specified as follows: a. Direct care staff will be responsible for care and treatment in accordance with the plan of care. b. A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail. d. The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails.On 9/22/25 at 1:57 PM, during an interview and observation, Resident #34 had half bedrails on both sides of the bed. Resident #34 reported she had been weak when admitted and used the bedrails to help with turning and positioning in bed. She did not remember signing a consent form for bedrail use.On 9/23/25 at 11:55 AM, during an interview with Licensed Practical Nurse (LPN) #1, she explained Resident #34 had been at the facility for only a few months and she had observed the resident using the bedrails to assist with pulling herself up in bed and turning over.On 9/23/25 at 12:55 PM, during an interview with Certified Nurse Aide (CNA) #1, she explained Resident #34 used the bedrails to help turn during care but still required staff assistance at times.On 9/24/25 at 9:45 AM, during an interview with Maintenance #2, he explained he checks beds and bedrails daily but did not keep a log of his findings. He stated he ensured the rails were tight and attached properly to the bed.On 09/24/2025 at 2:20 PM, during an interview with the Administrator, she explained that the facility did not consider the rails in use to be bedrails and therefore had not completed consents or entrapment assessments. She stated the facility identified the rails as positioning bars and had consulted the facility's consultant, who also indicated that the rails were positioning aids. The Administrator described the rail on Resident #34's bed as approximately the length of her forearm (from fingers to elbow), which she believed did not meet the definition of a full bedrail.On 09/24/2025 at 2:50 PM, during an observation of Resident #34's bed and follow-up interview with the Administrator, she confirmed that the rail on the resident's bed extended beyond a positioning bar and was at least a quarter- to half-length bedrail. She stated she had not previously considered the rails to be classified as bedrails and therefore had not completed consents or (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entrapment assessments. While in the room, Resident #34 reported to both the State Agency (SA) and the Administrator that she used the bedrails to assist with turning and moving in bed and expressed that she wanted to keep them.On 9/25/25 at 9:36 AM, during an interview with Registered Nurse (RN) #1, she confirmed Resident #34 did not have an assessment for bedrails and entrapment, and one should have been completed.A record review of the admission Record revealed the facility admitted Resident #34 on 7/15/25 with diagnoses including Wedge Compression Fracture of the First Lumbar Vertebra.A record review of the Order Summary Report revealed Resident #34 had a Physician's Order, dated 07/21/25 for .May Have Assist Rail(s) For Bed Mobility.A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/22/25 revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. A review of Section GG revealed the resident had impaired range of motion on one side for both upper and lower extremities and required maximal assistance for turning and repositioning.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews and facility policy review, the facility failed to ensure food items were dated, labeled, stored, and maintained in a sanitary manner in accordance with facility policy and manufacturer instructions for one (1) of four (4) days of survey. Findings include:A review of the facility's policy, Food Receiving and Storage, revised July 2014, revealed, .Foods shall be received and stored in a manner that complies with safe food handling practices.Policy Interpretation and Implementation.6. All foods stored in refrigerator freezer should be covered labeled and dated.9.Wrappers of frozen food must stay intact until thawing .On 9/22/2025 at 10:36 AM, during an observation of the kitchen and interview with the Dietary Manager (DM), there was (1) gallon of Italian dressing stored in the refrigerator opened and undated. In the produce cooler, three (3) overly ripe cucumbers, (1) overly ripe head of lettuce beginning to deteriorate, (1) cucumber cut in half and left exposed/unwrapped, and three (3) green bell peppers overly ripe and beginning to dry were observed. The DM stated the green bell peppers had been used four (4) days earlier during meal preparation and confirmed she is responsible for checking produce daily. In Freezer #1, there was (1) bag of mini corn dogs opened, undated, and not repackaged, and (1) bag of beef fried steaks opened, undated, and not repackaged. In the dry goods room, observed (1) opened container of grape jelly stored on the shelf despite manufacturer instructions to refrigerate after opening. Additionally, a scoop was observed stored inside a container of cornmeal. The DM confirmed and acknowledged the findings and stated that produce is to be checked daily by the supervisor.On 9/24/2025 at 9:23 AM, during an interview with the Dietary Consultant, he stated his expectations for the dietary department are to ensure all food items are dated and labeled according to policy, that produce is monitored daily, and that established procedures are consistently followed.On 9/25/2025 at 12:45 PM, during an interview with the Administrator, she stated her expectation was for the Dietary Department to follow facility policy by repackaging and dating all opened food items and to follow manufacturer storage and handling instructions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and facility policy review, the facility failed to ensure infection prevention and control practices were maintained as evidenced by, not discarding isolation gowns that had fallen to the floor in the hallway, and placing the contaminated gowns back in to the clean supply bin designated for PPE use by staff for one (1) of two (2) PPE supply bins observed. Findings include:A review of the facility's policy, Infection Prevention and Control Program revised 2/16/2024, revealed, .This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.Policy Explanation and Compliance Guidelines.11. Supplies Protocol.c. Prepackaged sterile items are considered sterile until opened or damaged.On 09/25/2025 at 10:54 AM, during an observation of the PPE box adjacent to the conference room on F hall, four (4) plastic-wrapped isolation gowns were observed lying on the floor beneath the box.On 09/25/2025 at 10:56 AM, during an observation and interview with Housekeeper #1, she was observed picking up the isolation gowns from the floor and placing them back into the PPE box. Housekeeper #1 acknowledged that she picked up the gowns and placed them back into the supply box. She further stated that she had been told that when an item is picked up from the floor, it should be thrown away.On 09/25/2025 at 11:10 AM, during an interview with the Administrator, she stated she was made aware that Housekeeper #1 picked up PPE from the floor and placed it back into the supply box. The Administrator stated the purpose of infection control is to prevent the spread of infection and confirmed her expectation is that any contaminated PPE or other materials should be discarded immediately.